IN THE CORONERS' COURT OF THE NORTHERN TERRITORY

Rel No: D0317/2024

Police No: 24 130891

CORONERS FINDINGS

ROAD DEATH 59 OF 2024

*Section 34 of the **Coroners Act 1993***

I, Elisabeth Armitage, Coroner, having investigated the death of **a 60 year old Aboriginal female** and without holding an inquest, find that she was born on **10 February 1964** and that her **death occurred on 23 December 2024, at Stuart Highway, Knuckey Lagoon in the Northern Territory.**

Introduction:

These findings concern the death of a 60 year old Aboriginal female pedestrian. Her death was road death 59 of 60 in 2024.

In 2025 the Menzies School of Health Research published a report on Pedestrian deaths and serious injuries in the Northern Territory[1] (the Menzies Report) which identified that pedestrians are the most likely to be injured or die during collisions compared to any other road user and road crashes involving pedestrians are a significant concern in the Northern Territory (NT), accounting for 23.1% of road fatalities in the NT compared to 13.7% nationally.

The Menzies Report found that most pedestrian crashes occur in the evening between 6 and 10 pm and this crash occurred in that window, at 7.38 pm. Aboriginal and Torres Strait Islander people are (depending on the year) between 4.5 and 18 times more likely to be killed in a pedestrian collision than non-Indigenous people and this deceased was Aboriginal. Transport disadvantage and unstable housing are key risk factors for pedestrian crashes and this deceased was subject to both of those risk factors. This deceased was without consistent housing in Darwin and she was walking a long distance down a major highway in order to access the Darwin Sober Up Shelter (DSUS). The Menzies Report documented that many people at risk of pedestrian crashes had complex health needs, and this pedestrian had chronic health conditions and was regularly presenting at Emergency Departments (ED). Poor mental wellbeing and trauma may contribute to crashes and this pedestrian had a history of domestic family violence involvements. 57% of all crashes occurred in dark conditions and this crash occurred in the dark, in a section of road where

[1] Clifford, S., Lee, K.K., Ramsamy, R., Christophersen, C., Lamba, T., Dadi, A., Canty, R., Wardle, F. & Wright, C.J.C. (2025). Pedestrian deaths and serious injuries in the Northern Territory. Darwin, Menzies School of Health Research.

there were no street lights. 64% of crashes occur where the speed limit is over 70 kph and this crash occurred on a stretch of highway that had a 90 kph limit.

This crash occurred when this pedestrian was attempting to access the Darwin Sobering Up Shelter (DSUS). On 28 August 2024 another intoxicated Aboriginal female pedestrian who was departing the DSUS was killed as she crossed the Stuart Highway. Her death was road death 46 of 2024.

The Menzies Report concluded:

> Pedestrian injuries and deaths often occur in a **perfect storm** of factors involving road conditions (darkness/poor lighting and other challenges to visibility, high speed limits), factors related to the driver (alcohol or drug use, post-crash behaviour) and factors related to the pedestrian (presence on or near roads, physical and mental health, alcohol and drug use). Reducing or removing one factor within the storm may prevent a crash or reduce the severity of outcome if it does occur. For instance, increasing visibility on a road or reducing speed limits increases the ability of the driver to react to the presence of a pedestrian on the road, which can help to avoid a crash even when a pedestrian is present on the road.
>
> This approach to prevention invokes the Safe Systems Approach to road safety, which sees road safety as a shared responsibility, recognises that humans are fragile, people are fallible and that we therefore need a safe and forgiving road system. Pedestrians are the most vulnerable of all road users for obvious reasons. In the NT, our report illustrates the complexity of the lives and context of people identified as most at risk of pedestrian crashes, the solutions to which require significant investment in addressing social determinants of health. This is in no way to say that pedestrian crashes are intractable in the NT and our findings point to a range of prevention measures which can work together to reduce the incidences and severity of pedestrian crash outcomes in the NT.

The location of the DSUS creates the perfect storm, noting:

- **Its proximity to the Stuart Highway.**
- **The speed limit.**
- **The limited street lighting.**
- **The lack of a safe pedestrian crossing.**
- **The hours in which the DSUS can be accessed and exited.**
- **How it is accessed (including by people walking or taking a bus).**
- **Its purpose, namely, that it will be accessed by persons significantly affected by drugs or alcohol.**

It is the responsibility of the NT Government to mitigate this perfect storm. Consideration should be given to:

- Reducing the speed limit.
- Improving visibility with high quality street lighting.
- Creating a traffic light controlled intersection and pedestrian crossing.
- Increasing the resources of Night Patrol so that persons can more safely access the DSUS.
- Moving DSUS to a safer and more easily accessible location for its cohort.

Cause of death:

1(a)	Disease or condition leading directly to death:	**Multiple blunt force injuries**
1(b)	Morbid conditions giving rise to the above cause:	**Reported motor vehicle crash (pedestrian)**
1(c)		**Acute alcohol intoxication**

Following an autopsy on 27 December 2024, Forensic Pathologist, Dr John Rutherford commented:

Post-mortem CT scan

- Multiple facial, jaw, and skull vault fractures.
- Pneumocephalus with vacuolation of brain tissue.
- Atlantoaxial dislocation.
- Multiple right sided rib fractures.
- Disruption of thoracic and abdominal organs.
- Fracture midshaft right humerus.
- Fracture distal right radius.
- Fracture midshaft left humerus.
- Fractures mid to distal third left radius and ulna.
- Disruption of pelvic girdle (right sacroiliac joint fracture-dislocation, disruption pubic ramus).
- Fracture midshaft left femur.
- Fracture-dislocation left knee joint.
- Fracture-dislocation left ankle.

Medical history from clinical case record

14 December 2024: Royal Darwin Hospital emergency department. Presentation: central chest pain 60-year-old female presenting with central chest pain greater than one week in duration, pleuritic in type and radiating round the left side of the chest to the back. Also reporting a cough with yellow sputum and a sore throat with subjective fevers. Also had dysuria and bilateral lower back pain for more than one week with associated suprapubic pain. Suffered diarrhoea for the last four days. No obvious abnormality on chest X-ray. Antibiotics prescribed but she left hospital before taking them. The letter to the GP suggests considering a urinary tract infection and appropriate antibiotic treatment.

13 October 2024: Royal Darwin Hospital emergency department. Triaged as semi-urgent. Three-day history of central chest pain and one day history of shortness of breath. Reported a cough and some coryza. No systemic symptoms. Diagnosis: suffering from a lower respiratory tract infection and prescribed antibiotics.

17 September 2024: Palmerston Regional Hospital emergency department. Presenting complaint: assault. Left before being seen by a doctor.

09 September 2024: Royal Darwin Hospital emergency department. Triaged as urgent. Presenting problem: multiple injuries**.** Described as a patient with moderate ischaemic heart disease, hypertension, dyslipidaemia, chronic obstructive pulmonary disease, and recent ESBL (abbreviation presumed to mean extended-spectrum beta-lactamase producing bacteria) UTI, presented intoxicated after being assaulted by her partner. The immediate plan was to include a whole-body CT scan to evaluate potential internal injuries and monitor her alcohol level. An X-ray of the right wrist was planned to rule out fractures or other trauma. Diagnosis: Domestic violence. Disposal of patient not recorded.

04 September 2024: Royal Darwin Hospital emergency department. Triaged as non-urgent. No clinical data available. Left before being seen by doctor.

03 September 2024: Royal Darwin Hospital emergency department. Triaged as non-urgent. No clinical data available. Left before being seen by a doctor.

03 September 2024: Palmerston Regional Hospital emergency department. Triaged as non-urgent. No clinical data. Left before being seen by a doctor.

14 August 2024 Royal Darwin Hospital medical discharge summary. Principal diagnoses: -

- Ischaemic heart disease (moderate diffuse with normal left-ventricular function).
- Dyslipidaemia.
- Hypertension.
- Pulmonary melioidosis (2014).
- Chronic obstructive pulmonary disease.
- ESBL UTI (02/2024).
- Lung nodule on chest X-ray.

She was admitted to hospital but took her own discharge prior to review and further investigations. The clinical diagnosis was right-sided pyelonephritis manifested by one week of abdominal and back pain on the right side associated with dysuria, subjective fevers, chills, and vomiting.

13 August 2024: Royal Darwin Hospital emergency department. Triaged as semi-urgent. Presenting problem: pain in the loin. Discharged from the emergency department with a diagnosis of pyelonephritis. Medical admissions note. 60-year-old female long grasser with a one-week history of dysuria and back pain. Past medical history of moderate diffuse ischaemic heart disease with normal left-ventricular function, hypertension, dyslipidaemia, pulmonary bacterial melioidosis (2014), lung nodule on chest X-ray. Medication comprised amlodipine, aspirin, atorvastatin, paracetamol, salbutamol, and pantoprazole. Admitted to ward for antibiotics.

Numerous other entries of similar nature.

Specimens were taken for toxicological analysis

Results: Forensic Science Case Number: 2500118

Preserved femoral blood Alcohol **0.18 %**

Preserved femoral blood Gamma-hydroxybutyrate not detected

No other drugs listed in the Scope of Analysis were detected in the preserved femoral blood.

Police investigation:

A coronial investigation by police found no suspicious circumstances surrounding this death.

There was no prosecution of the driver as the crash was unavoidable.

Background:

The deceased pedestrian was born on Groote Eylandt. She had four siblings. She worked in schools and for the Community Development Program. She was known to be very generous with her time, especially with her nieces and nephews, and was always willing to help her family and community.

Circumstances:

In December 2024 the deceased and her partner, W, were living a transient lifestyle in Darwin. They were frequently attending the Darwin Sober Up Shelter (DSUS) on Tivendale Road. The last day they attended was Saturday 21 December 2024.

On Monday 23 December 2024 the couple were drinking together in Casuarina.

W told police that they were intending to sleep at the DSUS and were walking there. W was in front and the deceased was trailing behind quite a distance.

For an unknown reason, but possibly due to health or exhaustion, the deceased positioned herself in the left lane of the Stuart Highway, Knuckey Lagoon, approximately 10 metres east of bus stop 389. The deceased was reported to be in a 'reclined seated' position. She had almost made it to Tivendale Road, where she would have turned to walk to the DSUS.

At this time SA was driving a white 2004 Holden Commodore Sedan in the left lane, inbound to Darwin to see the Christmas lights. He was driving with a front passenger seat, two friends in the rear side seats, and a10 month old who was seated in a child seat.

As the driver approached the deceased's location he said he initially believed the deceased to be a palm frond laying in the lane. As the distance between the driver and the deceased shortened, he positively identified the deceased as a person in the roadway and applied heavy braking and attempted to turn right to avoid the deceased.

The deceased was struck in the head by the front driver's side bumper bar and knocked to the road surface. The deceased was subsequently run over by the Commodore as it continued to travel inbound.

The deceased tumbled and rolled approximately 20 metres from the area of impact.

The deceased came to rest in a contorted position and suffered catastrophic injuries, including fractures to her skull, ribs, pelvis and both arms and legs due to the collision.

The driver bought the Commodore to a stop in the sealed shoulder on the left side of the highway. He immediately exited the Commodore and ran back to where the deceased had come to rest.

The crash on the Stuart Highway, approximately 80 metres west from the intersection of Tivendale Road, was reported to police at 7.38 pm on 23 December 2024 by a passenger of the Holden.

W said that he heard the car hit the deceased, however, because it was dark he wasn't able to see anything and he continued to DSUS.

Vehicle occupants reported seeing an unknown Aboriginal man standing in the bus stop structure as they ran to the deceased's location.

They attempted to assist the deceased, however, they found the deceased was not breathing and they were unable to locate a pulse.

Several other motorists stopped after the crash to assist and several called 000.

They reported that after they had attempted to assist the deceased, they noticed that the Aboriginal man was no longer in the bus stop shelter and that they did not see the person leave.

St John paramedics attended and assessed the deceased before she was declared deceased at 7.53pm.

Attending Darwin Traffic Operation members conducted patrols of the area to try and locate the unknown male, however, the patrols were unsuccessful.

Major Crash Investigation Unit members attended and processed the scene and obtained scene photographs and conducted a terrestrial survey.

The deceased's identity was unknown at the time, but she was subsequently identified by fingerprint comparison.

The couple were linked to an address in Malak. Efforts were made to locate W at the address. Residents and family located in Malak informed attending members that W had left Darwin after the deceased's death.

A 'To Be Spoken To' flag was added to W's profile on Ser Pro.

W had no further involvements with NT Police until he was located living rough in Katherine by members on the evening of 17 March 2026 during patrols in the flood support operation. W had no fixed place of abode or mobile phone.

Darwin Sobering Up Shelter records:

Due to the proximity of the Darwin Sobering Up Shelter (DSUS) to the crash site a Coroners Order was served on the DSUS on 19 March 2026. DSUS records revealed that the deceased had slept at the DSUS for 10 nights from 8 December until 21 December 2024 and that W had also slept there on 9 occasions from 9 December 2024. From the admissions times noted it was obvious they were together at each of those times from 9 December 2024. On the night of this fatal crash W was a DSUS walk-in admission at 7.55 pm, that is 17 minutes after this fatal crash was reported to police. W did not alert or inform the shelter of the incident.

Vehicle/driver/inspection/tests:

The licensed driver was subjected to roadside alcohol and drug testing, returned negative results.

The vehicle was a 2004 white Holden Commodore Sedan bearing NT registration.

On 29 January 2025 the Holden Commodore was inspected by Motor Vehicle Registry Inspectors.

Headlight mapping was conducted on the Holden Commodore. Both headlights were operational. The low beam headlight throw distance exceeded the minimum distance of 25metres set by Section 78(2) of the Australian Light Vehicle Standards Rules 2015.

The Commodore was in good operational order. A dash camera was located in the Commodore. The camera was seized, and the internal memory card was assessed by the Digital Forensics Unit, however, no footage capturing the crash was located.

Road Features and Conditions:

This section of the Stuart Highway is four lanes with two inbound and two outbound lanes. The inbound and outbound lanes are separated by a nature median strip.

The roadway is sealed and in good condition.

Bus stop 389 is positioned on the left side of the inbound lanes. A short bus turnout lane is positioned to the left of the outer inbound lane, alongside the bus stop. The posted speed limit is 90 km/hr.

Weather and Lighting Conditions:

The weather was fine with no rain.

There are no streetlights installed at the bus stop or along the section of the highway where the deceased was positioned.

Streetlights are installed at the intersection of Tivendale Road, approximately 80metres east of the crash location. The streetlights provided minimal lighting to the crash location.

Banned Drinkers Order:

The deceased had been subject to five Banned Drinker Orders (BDO) and at the time of the crash the deceased was subject to a current 6-month BDO which was due to expire on 28 December 2024. The deceased was issued the order by police when she was located drinking in public.

Domestic Relationship:

At the time of the crash the deceased was in a relationship with W. The couple had not been subject to a Domestic Violence Order, however the deceased had previously been listed as the protected person on four (4) separate domestic violence orders with historic partners.

A domestic violence review was requested from the Domestic Violence Command, and a Family Safety Framework (**FSF**) History Report was compiled by the FSF Senior Coordinator. In this report she details the FSF involvement between the deceased and W. The deceased had been referred to the Katherine Family Safety Framework in 2024 and the Darwin Family Safety Framework. The deceased was not accepted onto the Family Safety Framework.

The deceased had five active ‘To Be Spoken To’ flags on the police SerPro system. All five flags were in relation to obtaining version of events (**VOE**) from the deceased in relation to reported Domestic Disturbances. The last alert was dated 17 September 2024.

Option as to cause of crash:

The Crash Analysis Report concluded that the crash occurred due to the deceased pedestrian's position in the roadway.

The crash was unavoidable for the driver due to a combination of the pedestrian's positioning in the roadway, the lack of sufficient available lighting at the pedestrian's location, and the insufficient distance available for the driver to bring the Commodore to a stop or steer clear of the pedestrian once positive recognition had occurred.

Comment:

In road death 46 of 2024 I made the following recommendation:

> I recommend that the Department of Infrastructure and Logistics (DLI) within 12 months take all steps necessary to improve pedestrian safety in the vicinity of the Darwin Sobering Up Shelter including on Tivendale Road, Wongabilla Street, the Stuart Highway, Thorak Road and bus stops in that location, with special attention given to the intersections of Tivendale Road and Thorak Road with the Stuart Highway. The improvements should include but are not limited to: a review of the speed limit in combination with improved lighting to ensure vehicles travelling at the speed limit have an opportunity to see and avoid pedestrians; the installation of an Intelligent Transport System; and/or any other safety measures necessary to improve pedestrian safety and to alert drivers to the presence or likelihood of pedestrians.

I will make a similar recommendation in these findings noting that consideration should also be given to creating of a light controlled intersection and pedestrian crossing at the intersection with the Stuart Highway, increasing the capacity of Night Patrol, and/or moving the DSUS to a more suitable location with safer access for pedestrians.

Recommendation:

1. I recommend that the **Northern Territory Government** within 12 months take all steps necessary to improve pedestrian safety in the vicinity of the Darwin Sobering Up Shelter including on Tivendale Road, Wongabilla Street, the Stuart Highway, Thorak Road and bus stops in that location, with special attention given to the intersections of Tivendale Road and Thorak Road with the Stuart Highway. The improvements should include but are not limited to: a review of the speed limit in combination with improved lighting to ensure vehicles travelling at the speed limit have an opportunity to see and avoid pedestrians; the installation of an Intelligent Transport System; and/or any other safety measures necessary to improve pedestrian safety and to alert drivers to the presence or likelihood of pedestrians. Consideration should be given to creating a traffic light controlled intersection and pedestrian crossing, increasing the capacity of Night Patrol, and/or moving the DSUS to a location which is more suitable and safer for pedestrian access.

Decision not to hold an inquest:

Under section 16(1) of the *Coroners Act 1993* I decided not to hold an inquest because the investigations into the death disclosed the time, place and cause of death, the relevant circumstances concerning the death and I do not consider that the holding of an inquest would elicit any information additional to that disclosed in the investigation to date. The circumstances do not require a mandatory inquest because:

- The deceased was not, immediately before death, a person held in care or custody; and
- The death was not caused or contributed to by injuries sustained while the deceased was held in custody; and
- The identity of the deceased is known.